



# Iowa Department of Human Services

Terry E. Branstad  
Governor

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Lt. Governor

Charles M. Palmer  
Director

December 15, 2011

Michael Marshall  
Secretary of Senate  
State Capitol  
LOCAL

Charlie Smithson  
Chief Clerk of the House  
State Capitol  
LOCAL

Dear Mr. Marshall and Mr. Smithson:

Enclosed please find a copy of the report to the General Assembly relative to Analysis of All Payer Claims Database for the State of Iowa.

This report was prepared pursuant to directive contained in HF 649, Section 108.

Section 108 required the Department of Human Services in consultation with the Division of Insurance to investigate an all-payer claims database from multiple payers of health care. Investigation was to include costs and privacy implications. The department is reporting its findings and recommendations in this report as required.

Sincerely,

Jennifer Davis Harbison  
Policy Advisor

Enclosure

cc: Governor Terry E. Branstad  
Senator Jack Hatch  
Senator David Johnson  
Representative David Heaton  
Representative Lisa Heddens  
Legislative Service Agency  
Kris Bell, Senate Majority Caucus  
Josh Bronsink, Senate Minority Caucus  
Brad Trow, House Majority Caucus  
Zeke Furlong, House Minority Caucus



# **Analysis of All Payer Claims Database for the State of Iowa**

**December 9, 2011**

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### Summary

The purpose of this report is to inform the Iowa State Legislature of the opportunities, costs, and barriers to implementing an all-payer claims database.

### Background

#### *State Legislation*

In House File 649, Sec. 108. Health Care Cost Containment, All-Payer Claims Database, p 90.

"The department of human services in consultation with the division of insurance of the department of commerce shall investigate the costs associated with and the privacy implications of implementing an all-payer claims data from multiple payers of health care. The department shall report its findings and recommendations to the individuals specified in the Act for submission of reports by December 15, 2011."

#### *What is an "All Payer Claims Database"?*

The All Payer Claims Database (APCD) differs from current databases that are in existence today in that it contains data from all payers for healthcare services rendered by providers across the health care continuum; others have limitations. For example, the Medicare data base provides valuable information but only on those over 65 years of age or who have a disability. The Medicaid database is limited to the underserved and the low income population. The Hospital Discharge Database (HDD) provides a database on all populations including the uninsured, which cannot be tracked by either Medicare or Medicaid. These current data bases have critical gaps in information. Missing from the hospitalization data are the actual payments to the facility, data from ambulatory care centers and pharmacy services, which combined represent greater expenditures than some other categories.

State APCDs aim to include data on the fully-insured, self-insured, Medicare and Medicaid populations. APCDs typically include data from medical claims, pharmacy claims, and provider files from private and public payers (including Medicaid). These claims include a full range of services including primary care, specialist care, outpatient surgery, inpatient stays, laboratory testing, and pharmacy data. The information collected typically include patient demographics; diagnosis, procedural, and National Drug Code (NDC) codes; costs (include plan and consumer paid amounts); information about the type of service providers; and payer information (type of health plan).



A state APCD would provide a single database for Iowa stakeholders to address and evaluate the health care system and patterns, information about the population and the performance of health care provided to them, what is behind the driving force of these patterns, and if it would be possible to alter its course. Answers to such questions can be obtained as to what these factors are and can they decrease the cost of medical care; how can the current state of healthcare be reshaped to decrease the costs without affecting the quality?

By collecting all claims into one data system, Iowa could gain a complete picture of what health care costs, how much providers receive from different payers for the same or similar services, the resources used to treat patients, and variations across the state and among providers in the total cost to treat an illness or medical event. It is also a source of information for designing and implementing payment and delivery system reforms, such as pay-for-performance, episode-of-care payments, global payments, medical homes and accountable care organizations.

### ***History of All Payer Claims Database in Iowa***

The state of Iowa attempted an All Payer Claims Database through the creation of the Health Data Commission in 1982. The health data commission collected data from health insurers, but encountered a significant barrier that detracted from the overall usefulness of the database. Self-insured plans are subject to federal ERISA laws, not state regulation. Therefore, a state mandate to release health insurance utilization data does not apply to those plans. Over time the number of self-insured employers increased which decreased the amount of data collected from insurers and ultimately the utility of the All Payer Claims Database created by the health data commission. Additionally, uninsured individuals are not captured by health insurer data.

In the mid-1990s, the Iowa Hospital Association (IHA) began collecting utilization and financial data directly from hospitals allowing the data set to include all-payers (including self-pay) regardless of ERISA status. In 1997, the health data commission dissolved and the state contracted with IHA to capture the hospital data and serve as the intermediary for maintenance and dissemination of the data. This arrangement continues today providing a [complete data set](#) on inpatient, outpatient, and ambulatory utilization in Iowa hospitals. Most recently, the state entered into a Memorandum of Understanding with IHA to ensure the collection of hospital data as well as the protection of personal health information during the maintenance and dissemination of the data.

Data not currently available in Iowa includes utilization and financial data for services provided in freestanding non-hospital owned ambulatory surgical centers, physician offices, and outpatient pharmacy.

### ***APCD and the Health Information Network***

The Iowa Health Information Network (HIN) is a tool to facilitate the exchange of clinical information between the health care team members. Data will be kept in a federated model, with providers maintaining an “edge” server of secure clinical information that is accessible only to the HIN. The Health Information Network will provide a central master patient index to uniquely identify patients across providers. It will also maintain a record locator service to allow emergency rooms to quickly find patient medical history from the source edge server. Finally, the HIN will maintain a directory of providers and their electronic address to allow secure and confidential electronic exchange of medical records.

The HIN will not contain billing or payment information. Due to the nature of a federated model, the data available to the health information network will not be optimized for population analytics.

### **Potential Use of APCD data**

“Maine has one of the oldest all-payer, all-claims databases in the nation. Data submission began in January 2003, and the first release of information was April 2005. The database is supported by a surcharge on providers and payers. The eligibility and claims data have been used to identify need for, use of and cost of care by various groups, including: service need; use and cost for chronically ill patients; need for and use of mental health medications by children; and statewide costs and geographical variation in emergency department use.

New Hampshire has implemented an all-payer, all-claims database, while Vermont and Utah are building theirs. New Hampshire has used its all-payer database to compare child health, access, prevention, care management, utilization and payments for the state’s SCHIP participants and commercial insurance members. Additional studies are planned on prevalence and cost for cardiovascular disease, diabetes, chronic respiratory disease, and mental health.

In Vermont, state policy makers were convinced of an all-payer, all-claims database’s value because of the limitations of hospital discharge data to give a comprehensive



picture of access to care, cost containment, consumer and purchaser reporting, and quality efforts.”<sup>16</sup>

### Potential Use Cases:

- Source of data for risk-adjustment methodologies for the Health Benefit Exchange established under the Affordable Care Act.
- Data-driven policy and legislative efforts
- Private and public sector contracting decisions
- Benchmarking Medicaid payments to commercial payer plans
- Analytics to better understand patterns, cost, and quality of care
- Access to primary care for children and adolescents
- Access to preventative/ambulatory health services for adults
- Rate of claims for cardiovascular disease
- Rate of claims for mental health
- Health care cost and utilization management
- Public health tracking of injuries treated in the primary care setting
- Public health analysis of diseases across settings and across payers
- Community health assessment
- Verification of patient volume for Medicaid EHR incentive program
- Insurance reform: rate review
- Source of data for initial and ongoing evaluation of medical home
- Source of data for initial and ongoing evaluation of Accountable Care Organizations
- Health Care Price Transparency

### ***APCD and 76 Fed Reg. 41930 (July 15, 2011)***

In July, the federal Department of Health and Human Services released a proposed rule entitled Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment. Subpart D – State Standards for the Risk Adjustment Program, section 153.340 on page 41954 discusses Data Collection under risk adjustment. These rules require the State, or HHS on Behalf of the State, to collect risk-related data to determine individual risk scores that form the basis for risk adjustment. Any state with an all payer claims database that is operational on or before January 1, 2013 may request an exception from the data collection minimum standards, by submitting the APCD technical specifications and proposing necessary modifications to support risk adjustment activities.

If the State were to pursue an all payer claims database, those efforts should be coordinated with the implementation of the Affordable Care act data collection efforts to avoid duplication.

### Overall Challenges

- Capturing data for self-insured populations due to ERISA or the uninsured unless collect directly from providers
- Cost of establishing and maintaining an APCD and publishing and analyzing database information can be significant
- Engaging and educating all major stakeholders, especially the self-insured groups.
- Determining governance and funding
- Identifying data sources and how it will be managed, stored and accessed
- Development issues
- Technical issues-capturing data on the uninsured population
- Identifying the total cost of the health care services, as service pricing can vary depending upon plan types, such as a PPO or HMO
- Both health care payers and providers are currently saturated with information technology projects to support meaningful use and the conversion to ICD-10.

### Privacy and Security Issues

One of the main concerns for consumers is about privacy and security issues. Different approaches have been taken to help avoid further concerns such as; Patient identifiers- not to collect direct identifiers but assigning specific identifiers, adopt an encryption method and restricting the release of information that can directly or indirectly identify an individual. States can impose penalties for misuse or inappropriate disclosures. Another benefit of using patient identifiers is for future use with a Health Information Exchange Network. This same identifier can be used for identification.

According to the APCD Council, most state APCDs do not collect direct patient identifiers for patient privacy and security protection purposes, but more are doing so and the trend is for all states to do this. The reasons behind this are for comparative effectiveness research, analytics to support health care reform policy evaluation, to provide insurance departments' HBEs with historical information, and to potentially augment incomplete HIEs with service information from APCDs <sup>2</sup>.

If patient identifier information is included, HIPAA compliance issues will be significant. The collecting entity will need business associate agreements with each entity and need



to undergo and comply with a full security assessment under HIPAA HITECH regulations.

### Cost

Determinations of cost will depend on the number of payers that are participating. Each payer is a source that has to be mapped into the system and tested prior to running live. Each additional payer or data source means more platforms required for different services such as medical, dental, pharmacy, which will increase the effort. In-house data management or outsourcing will also have an effect on the costs of the APCD as well as the following:

- Number of covered lives
- Number of carrier feeds or data sources
- Scope of the APCD will also determine the number of data sources
- Adoption of a common/consensus state APCD data collection standard vs. a state-specific format.
- Location of the agency where the APCD is to be housed
- Planned users and uses for the APCD
- What information will be produced and available?
- Will the agency outsource the analytic functions to a vendor or will analyses be conducted in-house?
- Who will manage the requests for data and reports to be run?
- Will there be a website and who will manage it?
- How much will it cost to produce data sets/reports

The APCD council research indicates that start up costs would range from \$500,000 to \$2 Million. These numbers are for states ranging from 1.3 million to 5.5 million covered lives.

The Federation of Iowa Insurers has concerns regarding the cost to payers and/or providers to provide data to an all-payer claims database. The concerns increase with the implementation of the Affordable Care Act, which imposes strict restrictions on medical loss ratios of payers by limiting the overall percentage payers can spend on administrative costs. Mandating additional administrative costs in such an environment poses tremendous challenges for payers.

In Medicare, providers are paid for the data they report because policy makers understand not only the burden imposed on providers to report information, but also the value inherent in the data itself. The legislature should consider the cost of a mandate

to provide data, and consider how those costs could be borne by those entities who will benefit from the data.

### Funding options for APCDs

- General appropriations (e.g. New Hampshire)
- Fee assessments on public and private payers (health plans) and facilities (Maine)
- Medicaid Match (e.g. Utah and New Hampshire)
- Data Sales (e.g. Maine, Vermont, Wisconsin)
- Broad data release to allow other organizations such as academic centers and think tanks to secure funding for analytics (New Hampshire)
- Membership dues
- User fees
- Data access fees
- Assessments (Vermont finances HIT through an assessment of 0.199 of one percent of all health insurance claims for Vermont members. This funds the Health Information Exchange as well as the APCD)
- Grants
- Penalty fees

### States with APCDs

Iowa (Hospital Only) [Reporting is statutorily required and the Iowa Department of Public Health has entered into a memorandum of understanding with outside vendor (IHA) for the collection of hospital inpatient and outpatient discharge data as well as the protection of personal health information. (Iowa Code 135.166; 1996 Iowa Acts, ch. 1212, section 5, subsection 1, paragraph "a", subparagraph (4); 641 IAC 177.3)]

#### States with existing public systems

- |                 |                 |
|-----------------|-----------------|
| ✓ Kansas        | ✓ New Hampshire |
| ✓ Maine         | ✓ Utah          |
| ✓ Maryland      | ✓ Vermont       |
| ✓ Massachusetts | ✓ Oregon        |
| ✓ Minnesota     | ✓ Tennessee     |

### States with private, voluntary APCDs

- ✓ Louisiana
- ✓ Washington
- ✓ Wisconsin

States have used APCD analyses to answer questions in each of these areas. For example, states have used APCD data to:

- Develop a tiered-network insurance product for the small group marketplace (New Hampshire);
- Provide cost information to support consumer-driven health care choices, providing information about the varying cost of procedures in different medical facilities (Massachusetts, New Hampshire, Maine);
- Help employers understand variations in the cost and utilization of services by geographic area and in different provider settings (Maine, New Hampshire);
- Explore the value equation (cost and quality) for services provided (New Hampshire);
- Inform the design and evaluation plan of payment reform models including the medical home model and accountable care organizations (Vermont, New Hampshire);
- Evaluate the effect of health reforms on the cost, quality, and access to care in a state (Vermont, Maryland);
- Compare the prevalence of disease across a population (New Hampshire, Utah);
- Compare utilization patterns across payers to inform state purchasing decisions for programs such as Medicaid (New Hampshire) and to identify successful cost containment strategies (Vermont, New Hampshire);
- Determine payer competitiveness within the commercial insurance market (New Hampshire); and
- Estimate the cost of potential legislative changes affecting health insurance and later calculate the actual cost and impact of the legislation.

### Governance models

Options include, state, public, private and hybrid approaches similar to the HIN. Issues that need to be addressed include: procurement, requirements development, and day-to-day administration; mandatory versus voluntary participation; and other factors.

- **Non-Profit Public**



Private stakeholder board members, legislation would require carriers to participate and contribute claims data to the non-profit, legislation could further establish and advisory board to make recommendations.

- **State**

Managed by a state agency with legislative authority to collect and disseminate the data

These are in a stronger position to enforce reporting compliance than states with voluntary initiatives.

- **Shared Governance**

Agencies have overlapping legislative authority

## Stakeholder Perspectives

The following table is taken from the All-Payer Claims Databases, "An Overview for Policymakers". Miller, PB, et al. State Coverage Initiatives, Academy Health, May 2010

Private payers include insurance carriers, third-party administrators and pharmacy benefit managers. Public payers include Medicaid, Medicare, and Medicare Part D. The ones with ties to the government that are not included are TRICARE and Federal Employees Health Benefits Program (FEHBP).

Stakeholders	Benefits	Challenges
Policymakers	<p>The ability to make decisions on aggregated database from all payers. The ability to identify best practices enables the Authority to identify communities that provide cost-effective care and learn from their successes. Provides data on diagnoses, procedures, care locations, providers, provider payments and offer both baseline and trend data that will guide policymakers.</p> <p>Allows for targeted population health initiatives Allows reform efforts to be evaluated so that successful initiatives can be identified and replicated.</p>	
Consumers	<p>Make rational choices based on cost and quality information. Cost information will be made available on procedures for providers and carriers. Quality measure reporting will be made available. This is especially important for those consumers who have high deductibles or uninsured.</p>	Consumers concerned about privacy and security issues

## All-Payer Claims Database (APCD)

Stakeholders	Benefits	Challenges
Providers	<p>Aggregated data providing clear picture of care in all settings and from all payers within a practice.</p> <p>Supports provider efforts to design targeted quality improvement initiatives.</p> <p>Enables providers to compare their own performance with those of their peers.</p>	<p>Providers may object to payers reporting data about their practices, being concerned whether it will accurately reflect prices and quality and if it will account for variations in the complexity of cases</p> <p>Administrative costs of complying with various state database requirements</p>
Employers	<p>Make rational choices based on cost and quality information. Cost information will be made available on procedures for providers and carriers. Quality measure reporting will be made available. This is especially important for those consumers who have high deductibles or uninsured. Allows businesses to choose insurance products for employees based on price and quality.</p> <p>Provides access to information that gives businesses a better negotiating position.</p>	
Researchers	<p>Improved data base to perform quality research for to determine quality outcomes (for state population).</p>	<p>Administrative costs of complying with various state database requirements</p>
Public Health	<p>Provide population based health care data. Measure the rates of disease prevalence of chronic conditions and access to health care services and make geographic comparisons to study variations in these measures.</p>	<p>Administrative costs of complying with various state database requirements</p>
Medicaid –including Children's Health Insurance Program (CHIP)	<p>Reward the delivery of high value and efficient health care</p>	<p>Administrative costs of complying with various state database requirements</p>



## All-Payer Claims Database (APCD)

Stakeholders	Benefits	Challenges
		<b>Statutory Penalties</b>  Some states may require payers to submit claims data often for failure to do so in a timely manner- \$1000.00 for each week of delay in Massachusetts, \$500.00 per day in Oregon, and \$100.00 per day in Tennessee
Commercial Payers	<p>APCD Data base can support policy development.</p> <p>Vary depending on a state's data release rules, which will dictate how much information the payers will have access to.</p> <p>Can use information in provider contracting negotiations. Carriers can evaluate cost, quality and utilization rates across the entire population of a state.</p> <p>They can benchmark themselves against their competitors and public programs.</p> <p>Could assist in developing new programs, new products based upon additional information from the database.</p>	<p>Administrative costs of complying with various state database requirements</p> <p><b>Statutory Penalties</b></p> <p>Some states may require payers to submit claims data often for failure to do so in a timely manner- \$1000.00 for each week of delay in Massachusetts, \$500.00 per day in Oregon, and \$100.00 per day in Tennessee</p> <p><u>Risk of inappropriate access to proprietary information.</u> Claims data contains financial information that is proprietary to commercial payers. Allowing government to create a centralized database of individuals' sensitive health care information could threaten a competitive market. With a centralized database, the government will be able to glean proprietary information from claims such as discounts for various procedures that a plan negotiates with different providers. It is important for companies to maintain the secrecy of such information in order to compete in the</p>

Stakeholders	Benefits	Challenges
		<p>marketplace.</p> <p><u>Data challenges.</u> Claims data collected by states for an all payer claims database has been a big challenge. The variation in data content, format, layout and quality measures has led to duplication efforts, increased costs to the payers and to the state, risks related to inconsistent data processes, and hesitancy by health care stakeholders to embrace the information generated by these activities. Another key challenge is the varying definitions and methods for aggregating data by the different payers. Differences in the definition of individual data elements require states to adjust data prior to aggregating it. If an all payer claims database is implemented in Iowa, the Federation strongly recommends the use of standard data sets and standard elements within the data sets for all claims files submitted to the all payer claims database.</p> <p><u>Use challenges.</u> All payer claims databases are populated with administrative claims data, which by its very nature is limited to what information is generated by providers and payers involved in the payment of claims (e.g., patient identifiers, diagnostic codes, procedure codes). This data is</p>

## All-Payer Claims Database (APCD)

Stakeholders	Benefits	Challenges
		not clinical outcomes or premium data.
Self insured health plans Employee Retirement Income Security Act (ERISA)		States may not be able to obtain data from employers unless the information is available from the third-party administrators of the plans.



## Department of Health And Human Services' proposed rule entitled Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed Reg. 41930 (July 15, 2011) 45 C.F.R. § 153.340

### § 153.340 Data collection under risk adjustment.

(a) *Data collection requirements.* The State, or HHS on behalf of the State, must collect risk-related data to determine individual risk scores that form the basis for risk adjustment.

(b) *Minimum standards.* The State, or HHS on behalf of the State, may vary the amount and type of data collected provided that the State, or HHS on behalf of the State, uses the following standards for risk adjustment data collection:

- (1) The NCPDP claims transaction or the HIPAA standard ASC X12N 837 Health Care Claim transaction for all claims and encounter data;
- (2) The HIPAA standard ASC X12N 834 Benefit Enrollment and Maintenance transaction for all demographic and enrollment data; and
- (3) To ensure adequate data privacy standards, the State, or any official, employee, agent or representative of the State must use individually identifiable information only as specifically required or permitted by this part and must not disclose individually

identifiable information except as provided in paragraph (d) of this section.

(i) The State should interpret this provision as separate from the authority of other applicable laws for disclosing individual identifiable information under paragraph (d) of this section.

(ii) The State must implement security standards that provide administrative, physical, and technical safeguards for the individually identifiable information consistent with the security standards described at 45 CFR 164.308, 164.310, and 164.312.

(iii) The State must establish privacy standards that set forth approved uses and disclosures of individually identifiable information.

(c) *Exception for States with all payer claims databases.* Any State with an all payer claims database that is operational on or before January 1, 2013 may request an exception from the data collection minimum standards described in paragraph (b) of this section by submitting:

- (1) Technical specifications for the all payer claims database including data

formats;

(2) Proposed system modifications to support risk adjustment activities;

(3) Proposed system modifications to meet requirements set forth in paragraph (d) of this section and other Exchange-related activities.

(d) *Uses of risk adjustment data.* The State, or HHS on behalf of the State, must make relevant claims and encounter data collected under risk adjustment available to support claims-related

activities as follows:

- (1) Provide HHS with de-identified claims and encounter data for use in recalibrating Federally-certified risk adjustment models;
- (2) Provide HHS with summarized claims cost for use in verifying risk corridor submissions; and
- (3) Provide the reinsurance entity with summarized claims and encounter data from reinsurance-eligible plans for payment verification purposes and individual-level from reinsurance eligible plans for audit purposes.

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